Submission Date:_____

GUAM BOARD OF NURSE EXAMINERS

Application for

(Please check √ one box)

☐ **Initial** ☐ **Renewal** ☐ **Endorsement** ☐ **Reinstatement**

IMPORTANT NOTICE: Completion of this application form is necessary for consideration for licensure under the **Guam Nurse Practice Act (10 Guam Code Annotated § 12300 et seq.).** Failure to disclose all requested information may result in this application not being processed or may result in denial of this application. **All applicants for licensure renewal, endorsement and /or examination have an obligation to update and supplement the information and responses on this application if they change.** Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be **accurate** and **true.** Please note that the information provided on this application is subject to the public information laws of Guam.

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) Information (Please see page 11)

Carefully follow the directions on this application form. In addition, please note the following:

1. Type of print legibly with black or blue ink only.
2. The licensure and application fees are **NOT** refundable.
3. Disclosure of your U.S. Social Security number, if you have one, is mandatory. The disclosure is mandated by the **Social Security Act.** Your social security number will be provided to the **Attorney General's Office** to assist in the identification of persons who are delinquent in complying with the Child support, spousal support/alimony order or in the repayment of educational loans.
4. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change (e.g., a certified copy of your marriage license, divorce decree, or other court order).
5. Answer all questions. If not applicable, indicate N/A.

Supporting Documentation and Fees:

If you are applying for licensure as a (Check √ box):

☐ **RN** ☐ **LPN** ☐ **CNA** ☐**APRN** ☐ **CRNP** ☐ **CRNA**

☐ **Clinical Nurse Specialist** ☐ **Prescriptive Authority (Optional)**

Submit the following documents and fees:

1. Notarized application **(all applicants for Initial, Renewal and Reinstatement)**
2. 2x2 passport-size photograph taken within three months of the date of the application, signed and dated on the back of the photo **(all applicants for Initial, Renewal and Reinstatement)**
3. Official Transcripts **(for Initial and Certified Nurse Assistant Endorsement applicants only)**
4. Certification of Education **(for Initial and Certified Nurse Assistant Endorsement applicants only)**
5. Verification of Licensure **(for Endorsement applicants only)**
6. Verification of last employment **(for Certified Nurse Assistant Endorsement applicants any)**
7. Criminal background checks: **Police and Local Court Clearance dated within two months of the date of the application (all applicants for Initial, Renewal, Endorsement and Reinstatement)**
8. Copy of Current License of Certification with expiration date **(Endorsement and Initial Advanced Practice Registered Nurse applicants).**
9. Continuing Education hours – **15 contact hours for Certified Nurse Assistant: 30 – contact hours for Registered Nurse and Licensed Practical Nurse (for renewal and reinstatement applicants).**
10. Written explanation for lapsed license **(all applicants for Renewal, Endorsement and Reinstatement).**
11. Notarized copy of the CGFNS credentials education verification **(for all RN/LPN Initial applicants who are foreign graduates).**
12. Submit the correct application and License Fee by attaching (1) check or money order payable to **"Treasurer of Guam".**

Your application is NOT considered complete until all supporting documents and fees have been received by the GUAM BOARD OF NURSE EXAMINERS staff.

Applicant's Name _____ Applicant's Signature _____

GUAM BOARD OF NURSE EXAMINERS

(Please check √ one box)

□ **Initial** □ **Renewal** □ **Endorsement** □ **Reinstatement**

□ **RN** □ **LPN** □ **CNA** □**APRN**

PART I: Applicant Identifying Information

Complete this section of the form by providing all of the requested information. **You must notify the Guam Board of Nurse Examiners,** in writing, of any address change(s) after you file this application in order to receive any further notice.

Last Name	**First Name**	**Middle Name**	**Suffix (Jr., etc)**	**Social Security Number**

Current Residence Address (P.O. Box)
Permanent Mailing Address (if different for Current Residence Address listed above)
Current Employer: **Business Mailing Address of Current Employer:**
Preferred Mailing Address (Check √ one): □ **Current** □ **Permanent** □ **Business**
Identify any maiden name, surname, or any other names or aliases you have been known by or used and identify the reason for your name change:

Place of Birth **(List city, county, State or other further jurisdiction, country)**	**Date of birth (MM/DD/YYYY)**	□**Male** □ **Female**

Phone Numbers	**Email Address:**
Day:_____ **Evening:_____** **Cell Phone: _____**	

1. Citizenship

a. Are you a United States Citizen? **(Check √ box)** □ **YES** □ **NO**

b. If you answered **NO** to question "a" above are you:

□A qualified alien (as defined in 8 U.S.C.A. §1641)

□ A non-immigrant under the Immigration and Nationality Act (8 U.S.C.A. §1101 et seq)

□ An alien who is paroled into the United States under § 1182(d)(5) for less than one year.

□ A foreign national not physically present in the United States.

□ Other - Please provide detailed explanation.

c. Do you intend to seek entry into the United States for the purpose of performing labor as a healthcare worker, other than a physician? **(Check √ box)** □ **YES** □**NO**

Applicant's Name _____ Applicant's Signature _____

(Please check √ one box)

☐ Initial ☐ Endorsement ☐ Not Applicable

Part II: Educational Information

1. Name of Last Secondary School Attended: (High School)	**2. Last Secondary School location (City and State/Jurisdiction)**	**3. Date of Graduation:** **Or Date GED Earned: (Month/Year)** **Jurisdiction where earned:**

4. Post Secondary Education History: Starting with your undergraduate education, list all schools, colleges, and universities attended, whether completed or not, in chronological order. Use additional sheets if necessary.

College or University Name	**Location (City and State of Country)**	**Date of Attendance**		**Graduated? Yes or No If No, give number of credit hours earned**	**Degree Earned/Major**
		From	**To**		
		Month/Year	**Month/Year**		

5.Specialized Training:

List in chronological order from date of graduation to the present all professional post-graduate training not including continuing education coursework (i.e. residency, vocational training, practical of clinical training).

Institutional Name	**Location (City and State or Country)**	**Dates of Attendance**		**Did you Complete Training? (Check √ Box)**
		From	**To**	
		Month/Year	**Month/Year**	
				☐**YES** ☐ **NO**
				☐**YES** ☐ **NO**
				☐**YES** ☐ **NO**
				☐**YES** ☐ **NO**
				☐**YES** ☐ **NO**

6. Special Certification:

Have you earned specialized certification? (Check √ Box) ☐**YES** ☐ **NO**

If yes, what type_____ and certification number _____

Applicant's Name _____ Applicant's Signature _____

(Please check √ <u>one</u> box)

☐ Initial ☐ Renewal ☐ Endorsement ☐ Reinstatement

PART III: Record of Licensure Information

If you have ever been licensed, certified or registered to practice in the profession for which you are now making application, or held any other professional license, certification or registration complete the information requested below. You must identify the method by which you obtained your professional license(s), i.e. 1. Licensure by examination, 2. Score transfer, 3. Endorsement, 4. Grandfather/waiver provision, or 5. Reciprocity – in the appropriate column. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. You must include jurisdictions both within and outside the United States. **Failure to disclose all licenses, certifications or registrations held my result in denial of your application or other appropriate action.**

Jurisdiction	**Jurisdiction /Title of License**	**License Number/Name on License**	**How license Obtained(list applicable number from above)**	**Date of <u>original initial</u> issuance**	**If License is not current and in good standing, explain below or on a separate sheet**
Jurisdiction of Original (Initial) Licensure					
Jurisdiction of Current Licensure where you most recently have been practicing:					
Other Jurisdictions of licensure:					

PART IV: Record of Licensure Examination

If you have ever taken a licensure examination, **<u>in any state or territory of the United States</u>**, for the profession for which you are now making application, you must complete the information requested below. Each examination attempt may result in the denial of your application or other appropriate action. Use additional sheets if necessary.

Name of Examination Note: If an examination is administered in parts, each part should be listed separately	**Jurisdiction**	**Date of Examination**	**Passed/Failed/ Other (If Other, please explain)**

Applicant's Name _____ Applicant's Signature _____

(Please check √ <u>one</u> box)

☐ Initial ☐ Renewal ☐ Endorsement ☐ Reinstatement

PART V: Personal History Information

Please answer each of the following questions by putting a check √ in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. **All "Yes" responses <u>MUST</u> be explained in detail in a separate paper signed and dated.** Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

1.	Have you ever had any application for any certification or professional license refused or denied by any licensing authority?	☐ Yes ☐ No
2.	Have you ever been refused or denied the privilege of taking an examination required for any certification or professional licensure?	☐ Yes ☐ No
3.	Have you ever been dropped, suspended, placed on probation, expelled, fined or requested to resign from any post secondary educational program in which you were enrolled?	☐ Yes ☐ No
4.	Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave temporarily or permanently, or otherwise acted against by any certification or professional training program prior to completing the training?	☐ Yes ☐ No
5.	Have you ever voluntarily surrendered your certificate or license?	☐ Yes ☐ No
6.	Have you ever allowed a limited license to lapse, issued by any other licensing authority?	☐ Yes ☐ No
7.	Have you ever voluntarily surrendered any other certification or professional license?	☐ Yes ☐ No
8.	Have you ever allowed any certification or professional license to lapse?	☐ Yes ☐ No
9.	Has your certification or professional license ever been revoked?	☐ Yes ☐ No
10.	Have you ever been the subject of disciplinary action with regard to your certification or professional license, been sanctioned by any licensing authority, association, licensed facility, or staff of such facility?	☐ Yes ☐ No
11.	Has your privileges ever been restricted or terminated by any licensing authority, association, licensed facility, or staff of such facility; or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measure?	☐ Yes ☐ No
12.	Have you ever had any other certification or professional license revoked?	☐ Yes ☐ No
13.	Have you ever been the subject of disciplinary action by any licensing agency with regard to any other professional license?	☐ Yes ☐ No
14.	To your acknowledge, have any unresolved or pending complaints ever been filed against you with any licensing agency, association, licensed hospital/clinic, or staff of such hospital or clinic?	☐ Yes ☐ No
15.	Have you ever had a registration issued by a controlled substance authority revoked, suspended surrendered, limited, or restricted?	☐ Yes ☐ No
16.	Have you ever voluntarily surrendered a registration issued by a controlled substance authority?	☐ Yes ☐ No
17.	Has your application for accreditation, recertification ever been denied? (i.e. DEA)	☐ Yes ☐ No

Applicant's Name _____ Applicant's Signature _____

(Please check √ <u>one</u> box)

☐ Initial ☐ Renewal ☐ Endorsement ☐ Reinstatement

18.	Is there any disciplinary action pending against you by any licensing jurisdiction, the USDA, US Drug Enforcement Agency, or any state drug enforcement authority? If YES, where and when?	☐ Yes ☐ No
19.	Have you ever been charged with or convicted (including nolo contendere plea or guilty plea) of a felony (or criminal offense) in any state or in federal court (other than minor traffic violations) whether or not a sentence was imposed or suspended? If YES, attach a certified copy of the court records regarding the conviction, the nature of the offense date of discharge, if applicable, as well as a statement from the probation or parole officer.	☐ Yes ☐ No
20.	Have you ever been pardoned from a felony (or criminal) conviction?	☐ Yes ☐ No
21.	Have you ever had a record expunged from a felony (or criminal) conviction?	☐ Yes ☐ No
22.	Are you now or have you in the past five (5) years been addicted to any chemical substance including alcohol? (exclude tobacco and caffeine)	☐ Yes ☐ No
23.	Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease(s) considered chronic by the medical community, i.e.:1. Mental or emotional disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a **CNA, LPN, RN, APRN?**	☐ Yes ☐ No
24.	Have you ever been named as a defendant to a civil suit related to you profession (i.e. malpractice)?	☐ Yes ☐ No
25.	Have you ever been court marshaled or discharged other than honorably discharged from the armed forces?	☐ Yes ☐ No
26.	Have you been terminated from a position with a city, county, state, or federal position?	☐ Yes ☐ No

IF THIS IS A <u>RENEWAL</u> APPLICATION, PLEASE ANSWER THE FOLLOWING <u>ADDITIONAL</u> QUESTIONS:

27.	Since the date of your last application for renewal of your license, have you been addicted to or used in excess any drug or chemical substance including alcohol?	☐ Yes ☐ No
28.	Since the date of your last application for renewal of your license, have you been treated for a drug or alcohol addiction or participated in a rehabilitation program?	☐ Yes ☐ No
29.	Since the date of your last application for renewal of your license, have you had any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, including any disease(s) considered chronic by the medical community, i.e. :1. Mental or emotional disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in practice as a **CNA, LPN, RN, APRN?**	☐ Yes ☐ No
30.	Within the last two (2) years have you had a license or certification revoked or suspended, other disciplinary action taken, or an application for licensure or certification refused, revoked or suspended by any professional licensing authority of another state, territory, or country?	☐ Yes ☐ No

Applicant's Name _____ Applicant's Signature _____

(Please check √ <u>one</u> box)

☐ Initial ☐ Renewal ☐ Endorsement ☐ Reinstatement

PART VI: Child Support/Spousal Support or Alimony/Educational Loan Information:

In accordance with Child Support Public Law: application for renewal of a license, endorsement or a license shall include the applicant's Social Security number, and the applicant/licensee shall certify, under penalty of perjury, that he or she is not more **<u>90</u>** days delinquent in complying with a child support order, order for spousal support or alimony or educational loan repayment obligation. Failure to certify may result in a disciplinary action, and making a false statement may subject the licensee to contempt of court.

You must check √ one of the following:

☐ I am not more than **<u>90 days</u>** delinquent in complying with a child support order/order for spousal support or alimony/educational loan repayment obligation.

☐ I am more than **<u>90 days</u>** delinquent in complying with a child support order/order for spousal support or spousal support or alimony/educational loan repayment obligation.

☐ I am not currently under any child support order/order for spousal support or alimony/educational loan repayment obligation.

PART VII: Certifying Statement

"By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge, **and that the photograph attached hereto is a true likeness of myself.** I hereby authorize the Guam Board of Nurse Examiners to verify any and all information contained in this application, including information maintained in applicable data banks, and transmit this information to the Guam Board of Nurse Examiners. I authorize the Guam Board of Nurse Examiners to review files pertaining to my licensure and practice, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provide herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the Guam Board of Nurse Examiners."

_____ _____

Date Name of Applicant (Print)

_____

Signature of Applicant

Subscribed and sworn to me this _____day of _____, 20_____.

(Seal) _____

Notary Public

GUAM BOARD OF NURSE EXAMINERS
651 Legacy Square Commercial Complex
South Route 10, Suite 9
Mangilao, GU 96913

VERIFICATION OF LICENSE

PART I: To be completed by the applicant and forwarded to all appropriate licensing boards, including original state of licensure.

Name: (Last, First, Middle/Maiden)		Previous Name(s)	
Current Street Address:		City, State, Zip Code	
Date of Birth: (MM/DD/YY)	Social Security Number	Current License Number: Type RN ☐ LPN/VN ☐	State
Name as it appears on original license (Last, First, Middle/Maiden)		Original State of Licensure:	
Original License Number ☐RN ☐LPN/VN		Date Issued:	
Nursing Education Program Completed:		Location (City/State)	Graduation Date:
LIST OF ALL OTHER STATES OF LICENSURE State:_____Lic. No:_____Date Issued:_____ State:_____Lic. No:_____Date Issued:_____ State:_____Lic. No:_____Date Issued:_____ State:_____Lic. No:_____Date Issued:_____		I hereby authorize all identified Boards of Nursing to release my license data to the_____Board of Nursing. Signature _____ Date:_____	

PART II: To be completed by licensing board and forwarded to Board of Nursing listed at the top of this form.

This is to certify that the above named individual was issued license number _____Date Issued _____to practice:

☐ RN ☐ LPN/Vocational Nurse

Licensed by: ☐ **Examination** ☐ **Endorsement** ☐ **Waiver**	**Current License Status:** ☐ **Active** ☐ **Inactive** **Expiration Date:_____**

Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited placed on probation)?
☐YES ☐NO

Disciplinary Action Pending? ☐ YES ☐NO **(Explain Yes responses on the reverse side)→→→→→→**

Nursing Education Program Completed: Location (City/State)	Approved by State? ☐YES ☐NO Graduation Date	Graduated From: ☐ H.S. ☐ H.S. Equivalency ☐Completion of 10th Grade

STATE BOARD TEST POOL EXAMINATION							NCLEX	
	Medical Nursing	Psychiatric Nursing	Obstetric Nursing	Surgical Nursing	Nursing of Children	LPN/VN	RN	LPN/VN
Score								
Series/ Form #								

Number of times applicant wrote exam:_____ Dates_____ Exam in English? ☐YES ☐NO

Signature _____

SEAL

Title_____

State_____Date_____

GUAM BOARD OF NURSE EXAMINERS
651 Legacy Square Commercial Complex
South Route 10, Suite 9
Mangilao, GU 96913

RECORD OF PAYMENT

IDENTIFICATION

NAME:_____
(LAST) (FIRST) (MIDDLE)

MAILING ADDRESS: _____
(STREET OR P.O. BOX #)

_____
(CITY) (STATE) (ZIP CODE)

SIGNATURE:_____ DATE:_____

II. **VERIFICATION OF CERTIFICATE**
Please print the complete name used on original certification and your social security number
_____ ☐ RN ☐LPN ☐CNA ☐ APRN SS#_____
Full Name (Print)

III. FEE

Fee paid is **NON-REFUNDABLE**. Make all checks or money orders payable to **TREASURE OF GUAM**.

PLEASE CHECK √ YOUR REQUEST(S)

		NURSE ASSISTANT
$100.00☐ RN EXAM	$150.00 ☐ RN or PN Continuation of Full approval Fee	$50.00 ☐ Nurse Assistant Application for Exam
$100.00☐ PN EXAM	$150.00 ☐ APRN License Application Fee	$ 25.00 ☐ Nurse Assistant Endorsement
$100.00☐ Endorsement	$150.00 ☐ APRN Reinstatement of License	$ 40.00 ☐ Nurse Assistant Reinstatement
$125.00☐ Reinstatement for Lapsed or Inactive	$100.00 ☐ APRN License Renewal	$ 25.00 ☐ Nurse Assistant Certificate Renewal
$ 80.00☐ RN License Renewal	$ 75.00 ☐ APRN Temporary Work Permit	$ 25.00 ☐ Certification Verification
$ 60.00 ☐ LPN License Renewal	$ 150.00 ☐APRN Prescriptive Authority	$ 20.00 ☐ Reissuance of Certificate
$ 25.00 ☐ License Verification		$200.00☐ Nurse Assistant Program Approval Fee
	OTHER	
$ 25.00 ☐ Temporary Work Permit (RN, LPN, CNA)	$35.00 ☐ Examination Proctoring	
$ 20.00 ☐ Reissuance of License	$ 10.00 ☐ Nurse Practice Act	
$400.00 ☐ RN or PN Nursing Education Program Approval Fee	$ 10.00 ☐ Rules and Regulations	
	$ 1.00 ☐ Photocopy (Each Page)	

Present this form with payments to the cashier at the Treasurer's Office then return the processed form to **GBNE**.

OFF-ISLAND APPLICANTS: Return this form with your payment to GBNE at the above address.

FOR OFFICIAL USE ONLY

Payment: ☐ **CHECK** ☐ **MONEY ORDER** ☐**CASH** ☐**CREDIT CARD**
Field Receipt #_____ **Date Paid:**_____

GUAM BOARD OF NURSE EXAMINERS
651 Legacy Square Commercial Complex
South Route 10, Suite 9
Mangilao, GU 96913

GUAM NURSING CONTINUING EDUCATION REPORT

Please Type or Print (Use Black or Blue ink ONLY)

A. IDENTIFICATION: ( ) Mr. ( ) Miss ( ) Mrs. ( ) Ms.

1. Name:_____
   Last First MI Maiden

2. Email Address: _____Telephone: _____Guam Certificate No:_____

3. Current Employer: _____Position Title: _____

B. Continuing NURSING EDUCATION RECORD:
In compliance with the Nurse Practice Act **(Section 4.10)** the Guam Board of Nurse Examiners will be requiring proof of **30 Contact Hours** related to NURSING or HEALTH seminars/activities.

DATE	TOPIC	ORGANIZER'S NAME	HOURS
		Total Number of Contact Hours Reported:	

I understand that my application will not be accepted for processing until it has been completed in its entirety and I hereby affirm and declare that the above information is true and correct and that any fraudulent entry may be considered cause for rejection or subsequent revocation. It is also understood that the Guam Board of Nurse Examiners may conduct and audit of the registration activities reported on these forms at anytime.

_____ _____
Signature Date

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

The Emergency System for Advance Registration of Volunteer Health Professionals **(ESAR-VHP)** is a federal program created to support states and territories in establishing standardized volunteer registration program for disasters and public health emergencies.

The program, administered on the local level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through **ESAR-VHP**, volunteers; identities, licenses, credentials, accreditations, and hospitals privileges are all verified in advance, saving valuable time in emergency situations.

Why does Guam need ESAR-VHP?

In the wake of disasters and public health emergencies, many of our nation's health professionals are eager and willing to volunteer their services. And in these times of crisis, hospitals, clinics, and temporary shelters are dependent upon the services of health professional volunteers. However, on such short notice, taking advantage of volunteers' time and capabilities presents a major challenge to hospital, public health, and emergency response officials.

For example, immediately after the attacks on September 11, 2001, tens of thousands of people traveled to ground zero in New York City to volunteer and provide medical assistance. In most cases, authorities were unable to distinguish those who were qualified from those who were not, no matter how well intentioned.

There are significant problems associated with registering and verifying the credentials of health professionals volunteers immediately following major disasters or emergencies. Specifically, hospitals and other facilities may be unable to verify basic licensing or credentialing information, including training, skills, competencies, and employment. Further, the loss of telecommunications may prevent contact with sources that provide credential or privileges information.

The goal of the ESAR-VHP program is to eliminate a number of the problems that arise when mobilizing health professional volunteers in an emergency response.

Please indicate if you are interested in the program and would like more information about registering as a volunteer by making the box with a √:

☐ **YES**, I am interested to receive more information about ESAR-VHP.

☐ **NO,** I am not interested.

GUAM BOARD OF NURSE EXAMINERS
651 Legacy Square Commercial Complex
South Route 10, Suite 9
Mangilao, GU 96913

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (PRINT NAME), hereby authorize GBNE Guam Board of Nurse Examiners Office staff to release the following documentation to GMHA Guam Memorial Hospital which will be needed to verify the identification and clearance for the GMHA EASR-VHP Volunteers Application. The verification and background records will be attained and include the following documents:

1.) Police Clearance
2.) Superior Court Clearance
3.) District Court Clearance
4.) Licensure
5.) Training Certificate (release the following checked items and other when specified)

_____ NRP _____ ACLS _____ NIMS ICS (_____)

_____ BLS _____ PALS

_____ Other. _____

_____ _____
Signature of Applicant ESAR-VHP Volunteer Date

_____ _____
Witness by GBNE Office Staff Date

Documents released to:

_____ _____
GMHA ESAR-VHP Coordinator Date

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GMHA PLANNING DEPARTMENT AT 647-2221.